AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

The undersigned authorizes The Orthopaedic Center to release my health information as noted below.
To check status of your medical records request, call 866-641-4778. Requests can be faxed to 256-539-2666.

Please Print

Patient Full Name: _____ **Date of Birth:** _____

Patient Address: _____ **Other Names?** _____

City: _____ State: _____ Zip: _____ Phone #: _____

Release Information To

Name/Facility: _____ **Attention:** _____

Address: _____ **Phone:** _____

City: _____ State: _____ Zip: _____ **Fax** #: _____

Email address for record delivery: *Please ensure email address is legible!*

You must provide a valid email address, either your own or that of your designated recipient. Your records will be provided as an Adobe PDF file on BACTES Mail Express portal. If you do not retrieve your records within 30 days, they will be deleted. You will receive an email from Bactes.com containing instructions for accessing the records.

Purpose of Request: ☐ Personal ☐ Treatment ☐ Legal ☐ Insurance ☐ Transfer ☐ Other:_____

Information to be Released

If you fail to specify, a 1 year abstract will be provided.

An Abstract includes progress notes, labs, procedure notes & testing results. ☐ 1 Year Abstract ☐ 2 Year Abstract ☐ 5 Year Abstract

Date Range: _____**:** *(If you to fail to specify, the most recent will be provided.)*

☐ Progress Notes ☐ Radiology Reports ☐ Labs ☐ Operative Reports ☐ Injections ☐ Physical Therapy

☐ EMG Report ☐ Work Status ☐ Radiology Disk ☐ Billing Statement ☐ Other:_____

Authorization to Release Protected Health Information

I acknowledge and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results, or AIDS information.* _____ (*Please Initial)*

I understand that:

- ✓ I may refuse to sign this authorization and that it is strictly voluntary.
- ✓ My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
- ✓ I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation.
- ✓ **Unless otherwise revoked, this authorization will expire on the following date, event or condition:** _____**.** *If I do not specify expiration this authorization will expire in 90 days.*
- ✓ I understand that once the information is disclosed pursuant to this authorization, it may be re-disclosed by the recipient and the information may not be protected by federal privacy regulations.
- ✓ I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it.
- ✓ I can request a copy of this form after I sign and date it.

Please confirm that you have filled out this form in its entirety—if form is incomplete, or if protected information is not released, we may be unable to fulfill this request.

Signature*:_____ **Date:** _____

** For non-emancipated minors under the age of 19, a parent or guardian must sign release form. If patient is unable to sign, a copy of the legal documentation for patient's representative must be supplied with a copy of this form.*